

The Madras Clinical Journal

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CONTENTS

	PAGE
1. Herpes Zoster and Chicken-Pox ...	133
— V. K. Jagadischandran <i>et al.</i>	
2. Bronchiectasis ...	139
— L. Sivaraman	
3. Abstracts and Excerpts ...	143
4. Association Notes ...	146
5. Obituary ...	154
6. State President's Appeal ...	155
7. State Secretary's Announcement ...	157
8. 17th Madras State Medical Conference ...	157
9. National Defence Fund—Donations by Alembic Group of Industries ...	158
10. Announcements ...	159
11. Notes on New Products ...	160
12. Editorial Committee ...	Cover 3
13. Editorial Announcement ...	Cover 4



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The Madras Clinical Journal

JOURNAL OF THE MADRAS STATE BRANCH OF THE INDIAN MEDICAL ASSOCIATION
(WITH WHICH IS INCORPORATED THE "MISCELLANY")

Vol. XXIX

December 1962

No. 6

HERPES ZOSTER AND CHICKEN-POX

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HENRY PAUL, M.D.³ and K. V. THIRUVENGADAM, B.Sc., M.D.⁴

The concurrence of varicella and herpes zoster was first reported by Von Bokay in 1888. Since then there have been reports of the unusual combination of the two diseases. The concurrence of varicelliform eruption with herpes zoster has an incidence of approximately 8% of the cases and has been interpreted as indicating a close relationship between zoster and varicella (Mc. Callum, 1952).

The viruses obtained in tissue culture from cases of the two diseases are identical in size, cytopathic effect and antibody production; there is cross neutralisation with convalescent serum. They cannot be separated by existing laboratory techniques. Clinicians have long suspected their relationship because adults who had varicella often develop herpes zoster on contact with cases of chicken-pox,

and conversely, cases of varicella sometimes occur after contact with herpes zoster.

CASE REPORTS:

Case 1: Patient M, aged 25 years came for shooting pain on the right side of the chest in the distribution of the 7th dorsal spinal cord segment. He had moderate fever at the time of examination (Temp. 100° F.) and there were no marked constitutional disturbances. Physical examination did not reveal any sign of localising value. On the third day, the appearance of herpetiform vesicles on an erythematous base in the distribution of the 7th dorsal segment on the right side made the diagnosis obvious. Secondary causes for herpetiform eruptions were ruled out. Non-specific treatment for herpes zoster was commenced.

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The next day generalised varicelliform eruptions with a centripetal distribution were noted. Search for factors such as malignancy, etc. which might have suddenly lowered the resistance of the patient and which might account for the dissemination of the lesions was not fruitful. He made an uneventful recovery. The scars of the zoster eruptions were deep-seated and pitted with residual pigmentation, but the scars left behind by the generalised eruptions were not deep-seated. No laboratory studies for isolating the virus from the lesions in the case were possible.

Case 2: Mr. S., aged 20 years came for pain along the course of the sciatic nerve on the right side. Examination revealed herpetic vesicles upon an erythematous base distributed over the S_2 and S_3 segments on the right side. He did not have any disturbance of micturition. On a more careful examination, a generalised varicelliform eruption with a centripetal distribution was noted in this patient, especially on the anterior aspect of the chest. He was treated symptomatically and he made good recovery. Deep seated scars over the S_2 and S_3 segments on the right side and superficial nature of the scars of the generalised eruptions were noteworthy.

Case 3: Mr. T., 21 years of age had continuous fever for 3 days with severe head-ache and backache. There was no neck stiffness and Kernig's sign was negative. On the 4th day, erythematous patches appeared along the 5th dorsal segment on the right side which became vesicular the next day. There was considerable pain and severe tenderness in the above mentioned region. Subsequently varicelliform eruptions made their appearance on the

forehead, lateral aspects of the chest and the back of the left forearm. The fever subsided on the 7th day. He was treated symptomatically.

DISCUSSION :

These three cases showing the concurrence of varicelliform eruptions with herpes zoster bring out their close relationship. A varicella epidemic following exposure to zoster infection has been noted (Simpson, 1954). Exposure of a susceptible individual to one virus may produce either varicella or zoster depending upon his immunity.

There are certain clinical features of herpes zoster and varicella which are worth reviewing. While varicella usually occurs in epidemics, zoster is usually a sporadic disease. Varicella occurs infrequently after the twentieth year while zoster is rarely seen before 20 years. Varicella attacks the sexes equally, while zoster has a slightly higher incidence in males. Contact infections occur rarely in zoster, while varicella spreads more readily than most infectious diseases. The incubation period of herpes zoster is placed at from 7-14 days, while that of varicella is usually from 14-16 days. The constitutional symptoms which precede the eruptions may be slightly more severe in the case of varicella. The encephalomyelitis which occasionally complicates varicella is clinically similar to that accompanying herpes zoster; the complication in either disease is rarely fatal.

The concurrence of herpes zoster and chickenpox in the same person has been described mostly in the middle-aged or elderly persons. In all cases, a sparse eruption of chickenpox vesicles appeared on the trunk about a week after the onset of herpes zoster;

usually the zoster is either of the ophthalmic or intercostal distribution (Stanley Banks, 1949).

The vesicles of varicella and herpes zoster are the result of a ballooning of the cells with very little reticulation. Varicella and herpes zoster are frequently indistinguishable from the cytological changes alone. All recent work have confirmed the old impression that zoster and chickenpox are caused by the same virus. The slow difficult propagation in tissue cultures and cytological changes produced are the same for the viruses isolated from those two diseases. The viruses are identical in their appearances under the electron microscope. By all serological tests including fluorescein-tagged antibody, the virus of zoster and chickenpox are indistinguishable.

Role of Immunity in Chickenpox and Herpes Zoster :

Evidences are in favour of the view that the virus of "varicella" derived from contact with a case of zoster is identical with the virus of ordinary varicella. The clinical courses are indistinguishable as exemplified in the three cases reported. In fact, if one were not to see the segmental distribution of the zoster lesion, the distinction from chickenpox would have been impossible.

The concurrence of these two clinical types as illustrated in the three cases is a clinical demonstration of the probable identity of the virus. The difference in clinical picture has to be explained in terms of differences in immunity. Patients with high humoral immunity force the virus to localise within the central nervous system, whereas in those with poor humoral immunity the disease manifests itself in the generalised form. In other words, zoster in an

immunological sense is a recurrent form of chickenpox in an individual with a high humoral immunity.

In cases where "varicella" eruptions follow herpes zoster in the same patient, it seems likely that the antibody level was initially high enough to localise the lesion in the posterior root ganglion, but the antibody level had fallen subsequently giving rise to the generalised form of eruption (Simpson, 1954). Such seems to be the probable explanation in the cases reported in this paper.

SUMMARY :

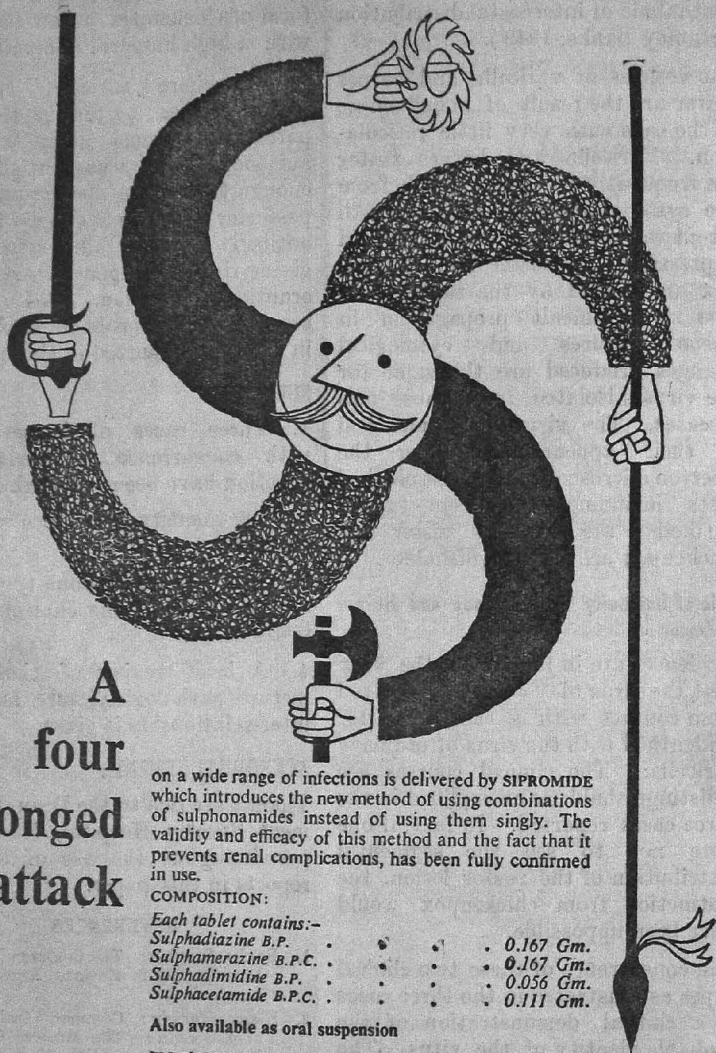
1. Three cases of herpes zoster with concurrence of varicelliform eruption have been reported.
2. The identity of the two viruses is stressed.
3. The role of immunity in the determination of the clinical picture is discussed.
4. A brief review of the clinical picture, pathologic picture and their inter-relationship is given.

ACKNOWLEDGEMENT :

Thanks are due to the Dean, Government Stanley Hospital, Madras for permitting us the use of the case reports in this paper.

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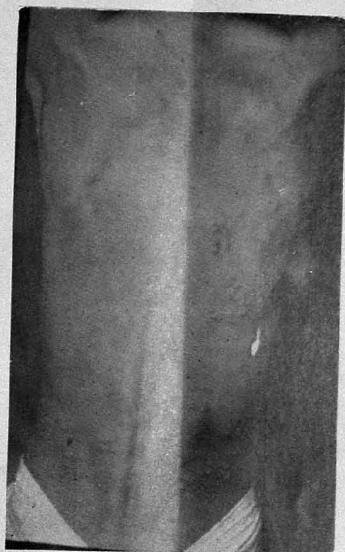


FIG. 1.

Case No. 1 — Showing herpetic vesicles along 7th dorsal segment and generalised varicelliform eruptions

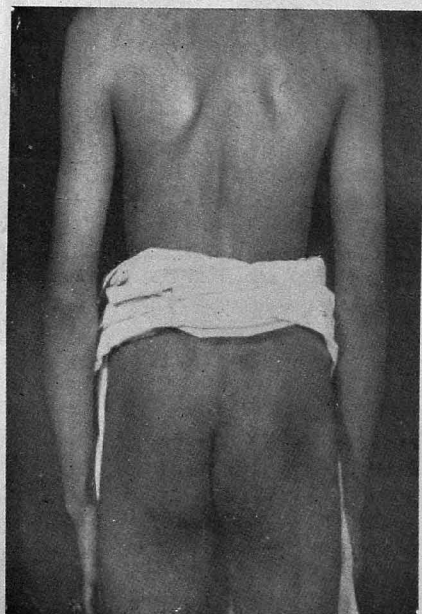


FIG. 2.

Case No. 2 — Showing herpetic vesicles over S_2 and S_3 segments on the right side.

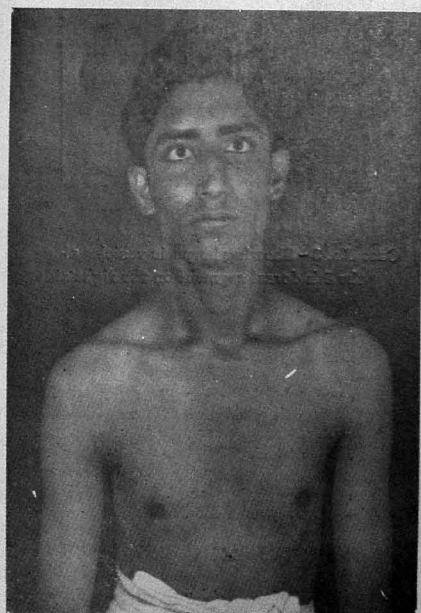


FIG. 3.

Case No. 2 — Showing varicelliform eruptions on the anterior aspect of the chest.



FIG. 4.

Case No. 3 — Showing herpetic vesicles along the 5th dorsal segment on the right side.



FIG. 5.

Case No. 3 — Showing varicelliform eruptions on the lateral aspects on the chest and left forearm.

BRONCHIECTASIS *

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Bronchiectasis is not purely a medical condition but is also a surgical condition. With the advent of thoracic surgery and its rapid development in the recent years, treatment of bronchiectasis by surgery has become established. But on the other hand with the increasing use of chemotherapy and antibiotics in the early treatment of respiratory and upper respiratory infections, the number of cases of bronchiectasis requiring surgical treatment have also declined and its incidence is low.

DEFINITION :

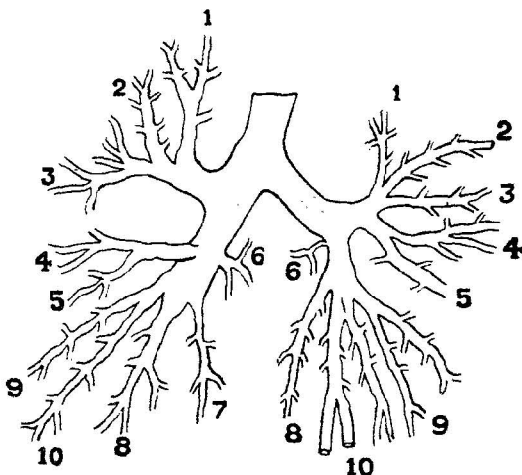
Bronchiectasis is an abnormal dilatation of the bronchi (air

tubes) and infection of the widened bronchi.

SURGICAL ANATOMY :

It is essential to know the surgical anatomy of the bronchial tree to understand the site of bronchi involved in bronchiectasis and to give effective treatment.

Anatomy of the bronchial tree: The trachea divides at the carina into the right and left main bronchi. The right and left main bronchi each in turn divide into ten broncho-pulmonary segments. (Diagram) Broch.



Broncho-pulmonary segments—Sketch from a cast.

R. Main Bronchus.

Upper lobe.

1. Apical
2. Posterior
3. Anterior

L. Main Bronchus

1. } Apico-posterior
2. }
3. Anterior

* Delivered at a clinical meeting of the Thanjavur District Branch of the I. M. A. on 25-2-1962.

Middle lobe.

4. Medial
5. Lateral

Lingula

4. Superior
5. Inferior

Lower lobe.

6. Apical lower
7. Medial basal (cardiac)
8. Anterior basal
9. Lateral basal
10. Posterior basal

6. Apical lower
7. Absent
8. Anterior basal
9. Lateral basal
10. Posterior basal

Broncho-pulmonary segments are roughly pyramidal in shape with their apices towards the hilum and bases towards the surface of the lung. Each bronchus is accompanied by a pulmonary artery. Pulmonary veins are intersegmental in distribution.

Aetiology: Bronchial dilatation is invariably secondary to some mechanical obstruction or inflammatory changes affecting the air tubes. Theories ascribed for bronchial dilatation are:

1. Congenital weakness of the bronchial walls.
2. Traction on the walls of the bronchi as a result of surrounding fibrosis.
3. Excessive bronchial pressure consequent on coughing.
4. To softening of the walls following retained secretions.
5. Current view - Atelectasis is a predisposing factor for bronchiectasis; and this may be due to obstruction from a foreign body, retained secretion, or glandular pressure.

Atelectasis leads to rapid absorption of gases in the lung distal to the block. Alveolar tissues collapse. The tension and traction of the elastic tissues in the alveolar walls leads to

pulling over of the mediastinum, pulling in of the chest wall, elevation of the diaphragm, and some compensatory emphysema. But once the limits of these effects have been reached, the traction acts on the bronchial walls, which must yield and be stretched. If the obstruction is removed, reventilation of the collapsed lung may result in restoration of the normal bronchial lumen. But when the collapse persists, a stagnant area remains. Secretions collect and become infected in course of time to produce a permanent condition.

Common causes of obstruction are:

(a) Extra-bronchial: From enlarged hilar glands due to measles, whooping cough, tuberculosis, hodgkins, etc.

(b) Intra-or endo-bronchial: Inhaled foreign body, inhaled purulent secretions (post-operative), pus from infected paranasal sinuses, spill-over from adjacent bronchi, pulmonary tuberculosis and bronchogenic carcinoma.

Bronchiectasis tends to affect such air tubes as cannot empty their secretions readily under the action of gravity, namely lower lobes, lingula and middle lobe. Left side greater than the right side, left side 65%. Secretions readily drain from dependent air tubes (upper lobes) and the infective element is minimal.

Pathology :

(a) In early uninfected cases, minimal changes.

(b) When obvious atelectasis is present, there is loss of alveolar pattern with aggregation of elastic and fibrous tissue.

(c) When infection is present, there are signs of inflammation in the parenchyma and peri-bronchial tissues, but the general bronchial structure is well maintained. There is an increase of fibrous tissue in the parenchyma.

(d) Minor dilatations of a temporary character occur in any form of pneumonitis. Many cases of chronic bronchitis reveal bronchiectasis.

Bacteriology : Mixed flora. *Spirocheta vincenti* and fusiform bacilli are responsible for the foetor of the sputum. *Pneumococcus*, *streptococcus*, *staphylococcus* and *tubercle bacilli* have all been responsible.

Incidence : Sex - equal. Many not diagnosed until adult life. Bronchiectasis may occur in the middle aged and even in the elderly.

Distribution : Lower lobes, most common. In 50% only one side is affected. Left more than the right. Right lower and middle lobes, left lower and lingula are common combinations. A bilateral picture of involvement of the left lower and lingula with the right middle lobes suggests that the bronchi were affected by a general hilar gland enlargement. Bronchiectasis involving adjacent segments without affecting the whole lobe probably results from pressure by glands of tuberculous origin. The whole lung may be affected and cystic dilatation with extreme fibrosis may occur in children.

Clinical picture : Ranges from being almost negligible to those of gross toxæmia with indications of pulmonary inflammation.

(a) Cough with purulent sputum.

(b) Most marked in the early mornings.

(c) Yellow to greenish in colour.

(d) Alteration of posture, in more advanced cases, will tip out secretions into healthy bronchial mucosa and elicit the cough reflex.

(e) Signs of chronic toxæmia; Lassitude, unpleasant breath, poor appetite, dry flaky skin, and lustreless hair.

(f) History of repeated colds and coughs, which go to the chest.

(g) Haemoptysis, an index of active ulceration; more often in adults.

(h) Advanced signs: Foetor, copious purulent sputum and obvious toxæmia with clubbing of fingers and recurrent pneumonitis ending in a condition beyond the scope of surgery.

Physical signs :

(a) In a dry case, negligible.

(b) Dullness at the base close to the spine, harsh breath sounds, loud leathery rales altering on coughing.

(c) Pleural infection causing empyæma.

(d) Metastatic abscesses - cerebral.

Aids to diagnosis :

(a) Bronchography: by injection of dianosol, either by local or general anaesthesia.

(b) Bronchoscopy: to detect a foreign body, tuberculous stricture, an adenoma or a carcinoma.

(c) Examination of sputum for A. F. B., E. S. R., and Mantoux.

(d) Investigation of associated paranasal infection.

Differential diagnosis :

Chronic bronchitis, phthisis, lung abscess, cancer.

Prognosis :

(a) Essentially a progressive disease, especially those developing in childhood. Expectation of life is proportionately greater in adolescence.

(b) Regression is very occasionally seen in childhood. Spontaneous resolution is unusually rare and must not be used as an argument for undue persistence with the conservative line of treatment.

Treatment :

Conservative line : Physiotherapy, expectorants, and antibiotics are the three main anchors of conservative treatment.

(a) Postural drainage, removal of secretions under the action of gravity.

(b) Breathing exercises, active inspiratory effects localized to the affected area.

(c) Attention to the septic foci, e. g. teeth, tonsils and paranasal sinuses.

Surgical treatment :

Operative excision of the affected area of the lung is the only chance

of producing a cure in bronchiectasis, but the removal of lung tissue must of course not be so extensive as to jeopardise the future respiratory function.

(a) Segmental resection or a single lobectomy is ideal.

(b) Lobectomy with removal of the middle lobe on the right side or lingular segments on the left is also compatible with complete functional recovery.

(c) Pneumonectomy, a more severe procedure, can give very good results.

(d) Removal of both lower lobes can also be considered. In bilateral operations risks are greater and the functional end results are less satisfactory, than if a less extensive removal is required.

CONCLUSION :

I have stressed the role of surgery in the treatment of bronchiectasis and dealt in brief the definition, surgical anatomy, aetiology, pathology, bacteriology, incidence, distribution, clinical picture, aids to diagnosis, prognosis and treatment of bronchiectasis.

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ABSTRACTS AND EXCERPTS

MALNUTRITION: (Cicely D. Williams)

Though good nutrition is recognised as essential to good health, malnutrition is still common everywhere. In the more prosperous countries there are problems of excess, yet pregnant women are encouraged to drink extra pints of milk daily in addition to their already copious diet, and doctors continue to prescribe unnecessary vitamins. To this picture of abundance, the widespread malnutrition of the developing countries provides a sombre contrast.

Those who are concerned with combating malnutrition in such countries often think in terms of overcoming food shortages; but it would be a mistake to think that lack of the necessary food is always, or indeed usually, the prime trouble. At an East African conference Miss Farmer said that, among 28 cases of Kwashiorkor, 48 causes underlying the disease were found. Only 4 of these were connected with lack of food—i. e., poverty. Social and psychological causes were responsible for 19 and medical (infections and other diseases) in 17. Another 8 were associated with “abrupt weaning”, which would cover food habits and lack of habituation rather than a shortage of food.

At the same conference Professor Gale concluded that “there is no overall basic shortage of foodstuffs in any of the three East African territories”. He recommended, therefore, that priority be given to persuading Africans to make more effective use of foodstuffs already available to them, particularly in the rearing of their children.

The Aetiology of Malnutrition

To solve the problem of malnutrition we must study the causal factors. These cannot be solved in a laboratory by the biochemists, nor yet by the bacteriologists and virologists who look for the organisms giving rise to enteropathies and malabsorption. Some workers look for the answer in short-term surveys, and a number of these have been carried out.

Kwashiorkor cannot be abolished merely by supplying extra proteins. In some cases in West Africa it was found that sweetened condensed milk added to the maize or cassava porridge produced good results. The fatty liver is unable to store much glycogen, and the easily absorbed sugar prevents serious hypoglycaemia.

The Role of the Hospital

It is now widely recognised that the best form of preventing disease may lie in treatment. In treating a minor condition, one is preventing a major catastrophe. Some of the most valuable work on nutrition has come from hospitals in East and West and South Africa, Guatemala, India,

Malaya, and Jamaica. Diseases can be prevented and the people educated in prevention when cases can be studied, diagnosed, treated, and then followed up efficiently. These hospitals are few and far between; but it is in and from them—and nowhere else—that the problems can be most readily appreciated.

— *The Lancet, London, August 18, 1962.*

* * * *

THE EFFECT OF TRACHOMA VIRUS VACCINE ON THE COURSE OF EXPERIMENTAL TRACHOMA INFECTION IN BLIND HUMAN VOLUNTEERS.

A strain of elementary body virus isolated from a trachoma patient in Taiwan has been proven capable of reproducing trachoma by inoculation of 6 human volunteers. Virus material from the 7th passage in embryonated hen eggs caused the clinical picture of trachoma in every inoculation. In each inoculation, the disease started with acute follicular conjunctivitis which progressed for 4 months and then persisted with chronic changes until 9 months when treatment was begun. The illness was generally more acute than in natural trachoma. The cornea was involved with keratitis and pannus; the conjunctiva showed gelatinous follicles with eventual cicatrization. Typical inclusion (H-P) bodies were demonstrated in conjunctival and corneal cells; virus was reisolated from each volunteer and CF antibody for a specific trachoma antigen demonstrated. Control inoculations with adenovirus type 4 and normal yolksac showed different clinical and laboratory findings.

Experimental trachoma vaccine was given to 3 of the volunteers to study its effect on the course of illness. In those receiving the vaccine, there was a modification of the disease and an antibody response. While the 3 volunteers who received placebo, each developed cross infection of their uninoculated eye and had an acute reactivation of the bilateral disease after 1 to 2 months of antibiotic eye ointment therapy, the vaccinated volunteers remained free of infection in uninoculated eyes and showed no relapse after ointment therapy.

Oral treatment with sulphamethoxypyridazine (1 gm. on 1st day, followed by a daily dose of 0.25 to 0.5 gm for a month) proved to be an effective and simple method of therapy for experimental trachoma.

— *J. T. Grayston & others, J. Experimental Medicine, 115: 1009-1022, (1962.)*

* * * *

COMMON CANCERS IN S. INDIA:

The table below shows that 80% of cancers that occur in S. India are those of upper alimentary tract, uterine cervix, breast and penis. Two-thirds of all cancers in women occur in the uterine cervix and breast.

Mouth & pharynx	39%
Uterine cervix	22%
Breast	10%
Oesophagus	6%
Penis	4%
Paranasal air sinuses	4%
Other carcinomas	4%
Sarcomas	11%

TABLE II.

Three year survival free from disease.

Region	Early lesions	Late lesions	Over-all survival
Mouth	87%	19%	29%
Pharynx	76%	7%	9%
Uterine cervix	67%	28%	42%
Breast	88%	23%	46%
Oesophagus	No early lesions	1.2%	1.2%
Penis	„	—	92%
Paranasal air sinuses	64%	16%	21%

Eighty out of 100 cases of cancer that occur in our midst are, therefore, preventable. The chewing and smoking of tobacco in moderation, restricted parity and prompt medical care of a cervical infection, breast feeding of children and the control of menopausal menstrual irregularities in time, penile cleanliness — all these are not unattainable ideals. If these simple controls in life can be accepted and if education can lead to better and earlier diagnosis of cancer, 95% of the disease can be conquered by the vastly improved medical knowledge of the present day.

— S. Krishnamurthi & V. Shantha, *The Antiseptic*, 59, 799, (1962).

ASSOCIATION NOTES

STATE COUNCIL

A meeting of the Council of the Madras State Branch of the Indian Medical Association was held at Srivilliputtur, Ramnad District, on Saturday the 14th July 1962. Dr. C. Nathamuni Naidu, the president presided.

After the president's introductory remarks calling the meeting to attention, he observed that it was very kind of the president of the Ramnad branch of I. M. A., Dr. S. Raju Ayyar to have made it possible for this meeting of the council to be held at Srivilliputtur. He reiterated his suggestion made at the last meeting that each branch of the I. M. A. should, by convenient turns, have the meeting of the council in its jurisdiction.

Resolution condoling the death of the following members of the association was moved from the chair :

1. Dr. J. K. Gnanaolivu
 2. Dr. G. A. Chandrasekharan
- } members of the Coimbatore
branch of I. M. A.
3. Dr. A. Lakshmipathy, member of the Madras city branch, I. M. A. The president made a special reference to the death of Dr. B. C. Roy, the Chief Minister of West Bengal.

Then routine business matters of the state office and of the Madras Clinical Journal were considered by the council.

The council took up for discussion a communication from the Director of Medical Services, Madras regarding the licensing of nursing homes in the state. After a lengthy discussion in which several members present participated, the council decided against the licensing of nursing homes run by registered medical practitioners.

The council decided to defer the constitution of a College of General Practitioners in Madras State pending the proposed formation of a National College of General Practitioners by the parent association.

On a representation by Dr. S. P. Shenbagaraman of Tenkasi, the council discussed the need for stipulating the rank of a doctor issuing a medical certificate and the following resolution was adopted by the council :

“This council feels that the existing stipulations over the issue of medical certificates whereby issue of certificates is restricted to persons ‘not lower in rank than that of a Civil Assistant Surgeon’ or persons ‘not below the rank of an M. B. B. S.,’ should be removed in view of the unification of the cadre of medical officers and the abolition of the cadre of sub-assistant surgeons. This council also requests that the certificates issued by all registered medical practitioners should be made acceptable and given the same weight and consideration as those issued by civil assistant surgeons”.

Then the council took up for discussion a representation from Dr. M. A. Khan of Dharmapuri on the question of refusal by some magistrates to visit the clinic of a private practitioner to record the dying declarations in medico-legal-cases. The hony. secretary told the council that since the question involved the interpretation of medical jurisprudence and the Cr. P. C., he referred the matter to the Director of Medical Services for an authoritative clarification of the position and that the reply is awaited. Winding up the discussion, the president observed that at present we are helpless in the matter and that we may, perhaps, await the clarification sought for from the D.M.S. The council agreed with this view and adjourned the subject to its next meeting for further discussion in view of a reply that may be received from the D. M. S.

The hony. secretary informed the council that in reply to a reference made to the Madras Medical Council on the propriety of a medical practitioner carrying his photo on the letter heads, the Registrar of the Madras Medical Council has informed that the medical council considered the subject and the executive committee considered that the printing of the photographs was wrong, not of a high standard of professional dignity and is unethical and that the person concerned has been warned and directed to drop the practice. The council recorded this communication with the view that the secretaries of all local branches would take note of the circumstance and apprise their members of the same.

The hony secretary placed before the council a letter received from the commissioner of the corporation of Madras which was a reply to the resolution of the council on the question of revision of the pay scales of the medical officers of the corporation. This communication gave details regarding the salary scales, etc. of the corporation medical officers and concluded by observing that there was no case for any further relief. The president observed that the council had decided to send a deputation and also indicated the personnel of the deputation, that the decision has been communicated to the hony. secretary of the Madras city branch of I. M. A. for further action and that the deputation may take into consideration the letter of the commissioner and do the needful.

BRANCH NOTES

Coimbatore Branch:

1. An extraordinary meeting of the Coimbatore District Medical Association was held on Thursday the 5th July 1962 at 6 P. M. Dr. Mrs. Anna Vareed, president of the association, taking the chair, moved a condolence resolution touching the death of Dr. B. C. Roy, Chief Minister of West Bengal.

It was resolved to nominate Dr. C. Nathamuni Naidu, for the presidency and Dr. T. V. Srinivasan and Dr. G. T. Gopalakrishna Naidu for the 2 vice-presidencies of the Madras State Branch of the IMA for the year 1962-63. The announcements on the proposed gynaecology symposium and the monthly clinical meeting on July 14th and August 11th were made by the president,

2. A monthly meeting of the Coimbatore District Medical Association was held on Saturday the 26th May 1962. Dr. Mrs. Anna Vareed, president of the association presided.

The president welcomed the speaker Dr. K. A. Kalyanam, M. B., F. R. C. S., D. M. R., Honorary Surgeon and Honorary Clinical Professor of Surgery, Erskine Hospital, Madurai on 'Random Thoughts on Current Surgical Problems' with review of personal series of cases. Dr. Kalyanam dealt on the various common surgical problems system by system and touched on the recent trends of surgical management citing his personal experiences.

3. The monthly meeting of the association was held on 14—7—1962 at 6 P. M. Dr. Mrs. Anna Vareed, president presided.

The president welcomed the speaker of the day, Dr. V. Hariharan, M. B., B. S., DPH (Hopkins), B. S. SC., Assistant Director of Public Health, Madras and his colleagues.

Dr. Hariharan addressed the members on 'The Role of B.C.G. Vaccination in the Control of Tuberculosis'. He pointed out the incidence of tuberculosis in the various states and a comparison with countries like Norway and Sweden. He stressed on the importance of the study of the statistical survey of incidence, prevention and control of tuberculosis and the comparative merits and difficulties of the various steps taken in different countries. He mentioned that isolation, treatment, health education and B. C. G. inoculation are four legs of a table. Without the one or other, the table cannot stand firmly. Then he touched on the programme of B. C. G.

4. A general body meeting of the Coimbatore District Medical Association was held on Saturday, the 11th August 1962 at 6 P. M. Dr. Mrs. Anna Vareed, president presided. The election of one president and three vice presidents to the central I. M. A. was held by secret ballot. Proposed by Dr. C. V. Ramaraj and seconded by Dr. C. N. Santhanam, Dr. N. S. Ramamurthy was elected unanimously as the associate secretary of the association in place of Dr. Mrs. Sarojini since resigned.

The president Dr. Mrs. Anna Vareed welcomed the speaker of the day, Dr. P. R. Balakrishnan M. S., Divisional Medical Officer, Southern Railway and P. A. to C. M. O., Madras and touched upon the experience of the speaker in this interesting field of peptic ulcer. Dr. Balakrishnan gave a very interesting lecture on 'Place of Gastro-jejunostomy in the Treatment of Peptic Ulcer'. He dwelt at length on the incidence of peptic ulcer amongst the employees of the railways, the nutritional factors involved in the incidence and the management of peptic ulcer. Then he traced the technical development of surgery in peptic ulcer, the recurrence rate of ulcer following various surgical procedures.

Later, the president announced a film show by the courtesy by M/s. William Warner Pharamaceuticals:

- (1) If I had an ulcer
- (2) Urinary infections.

5. A general body meeting of the Coimbatore District Medical Association, Coimbatore was held on Saturday, the 25th August, 1962 at 6 P. M. Dr. Mrs. Anna Vareed, president presided.

A condolence resolution over the sad demise of Dr. Adhisheshan, former Director of Public Health, was passed and the secretary was asked to convey the message to the bereaved family. The election of two vice-presidents to the Madras State Branch of the I. M. A. was held by secret ballot.

There was a symposium on some gynaecological problems in which Dr. Miss. P. Rukmini talked on 'Abnormalities of puberty', Dr. Miss. F. P. Isaiiah on 'Sterility' and Dr. Miss. Vijaya on 'Menorrhagia'. All the three speakers dealt on their topics in a very lucid and interesting way. The evening came to an end with an interesting film show on three different topics through the kind help of Dr. S. G. Rajarathinam.

6. A monthly meeting of the Coimbatore District Medical Association was held on 8—9—1962. Dr. Mrs. Anna Vareed presided.

The president introduced the speaker of the day Dr. A. B. Bhajekar, M. S., Department of Urology and Surgery, Christian Medical College and Hospital, Vellore and pointed out that the subject of the previous meeting was 'Sterility in Women'. She also touched on the usual mistakes by the husbands always blaming the wives for not producing children and marrying subsequently to make up the deficiency while, as in many cases, the mistake might have been all along on the part of the husband.

Dr. A. B. Bhajekar gave his interesting and illustrative lecture on 'Male Infertility' with suitable slides, their treatment and progress with statistics collected from the Christian Medical College and Hospital, Vellore. The whole audience appreciated very much the lecture to the end.

After a short discussion on the topic, there was a film show on 'Faces of Depression' kindly arranged by M/s. Suhrid Geigy Trading Ltd., Bombay though their representative Mr. Ramaswamy.

National Defence Fund — Donations from Coimbatore Doctors

A pleasant function was held at the premises of the Coimbatore District Medical Association on Saturday, the 17th November 1962 under the chairmanship of Dr. Mrs. Anna Vareed. Sri. Kamaraj, the Chief Minister of Madras was present on invitation when cheques for Rs. 5,000/-

on behalf of the District Medical Association and the Madras Clinical Journal and gold and jewellery from the members and their ladies and donations to the value of over Rs. 30,000/- in cash and gold by members of the public were presented to the Chief Minister for the national defence fund.

The editor will be happy to publish the detailed list of all contributions to the National Defence fund by the members of our association and their families in the coming issues of the Journal.

**List of members of the Coimbatore District Medical Association
who have contributed to the National Defence Fund.**

				Rs.	nP.
1.	Dr. M. N. Menon	...	...	500	00
2.	„ Mrs. Anna Vareed and Dr. K. P. Vareed	...	...	200	00
3.	„ A. G. Leelakrishnan	...	...	166	50
4.	„ Radha Kannan	...	...	150	00
5.	„ R. S. Rao	...	...	150	00
6.	„ K. V. Subramaniam (Path)	...	...	101	00
7.	„ K. R. Venkatasubba Iyer	...	...	101	00
8.	„ P. K. Kalyanaraman	...	...	100	00
9.	„ N. Jagannathan	...	...	100	00
10.	„ C. N. Santhanam	...	...	100	00
11.	„ S. R. Srikantan	...	...	100	00
12.	„ Venugopalakrishnan	...	...	100	00
13.	„ S. D. Jog	...	...	51	00
14.	„ C. V. Ramaraj	...	...	51	00
15.	„ V. Sriramulu	...	...	51	00
16.	„ Paul Ratnavelu	...	...	51	00
17.	„ K. Govindarajulu	...	...	50	00
18.	„ L. Munuswamy	...	...	50	00
19.	„ N. S. Palaniappan	...	...	50	00
20.	„ S. V. Subramaniam	...	...	50	00
21.	„ S. Sengaliappan	...	...	50	00
22.	„ B. Pratap Shetty	...	...	50	00
23.	„ G. S. Krishnamurthy	...	...	50	00
24.	„ C. R. Subramaniam	...	...	50	00
25.	„ T. Damodaran Nair, Anamallais P. O.	...	...	50	00
26.	„ G. N. Rajagopalan	...	...	50	00
27.	„ N. G. Kondaswamy	...	...	30	00
28.	„ Mrs. R. Sarojini	...	...	30	00
29.	„ P. Rajagopal Udupa	...	...	30	00
30.	„ N. Santhanam	...	...	25	00
31.	„ Mrs. R. Saradambal	...	...	25	00
32.	„ C. A. Vijayaraghavan	...	...	25	00
33.	„ J. A. Mascrenhas	...	...	25	00
34.	„ K. R. Venkatesalu	...	...	25	00
35.	„ V. S. Krishnaswamy	...	...	25	00
36.	„ Rathnaker Shet	...	...	25	00

			Rs.	nP.
37.	Dr. V. P. Subbian	...	25	00
38.	„ T. K. Rithuparnan	...	25	00
39.	„ S. N. Iyer & Mrs. L. K. Meenakshi	...	25	00
40.	„ Lalithamani	...	25	00
41.	„ G. T. Gopalakrishna Naidu	...	25	00
42.	„ Major N. Krishnaswamy	...	25	00
43.	„ C. Nanjappa	...	25	00
44.	„ B. Parthasarathy	...	25	00
45.	„ R. Padmanabhan	...	25	00
46.	„ C. B. S. Mani	...	20	00
47.	„ K. Narayanan	...	20	00
48.	„ V. Krishna Rao	...	20	00
49.	„ C. Subbian	...	20	00
50.	„ P. S. Parthasarathy	...	20	00
51.	„ V. Sundararajan	...	20	00
52.	„ J. Kolandaswamy	...	15	00
53.	„ G. V. Rajammal	...	10	00
54.	„ K. S. Vedachalam	...	10	00
55.	„ A. Rajagopal	...	10	00
56.	„ A. S. Selvaraj	...	10	00
57.	„ M. K. Saraswathi	...	10	00
58.	„ C. H. Venkateswaran	...	10	00
59.	„ Miss F. Ponnu Isaiah	...	10	00
60.	„ Mrs. K. M. Jalajam	...	10	00
61.	„ Shanthi Panikker	...	10	00
62.	„ I. K. Solomon	...	10	00
63.	„ R. Sundararajan	...	10	00
64.	„ C. M. Purushothaman	...	10	00
65.	„ M. A. Selvaraj	...	10	00
66.	„ R. Rajendran	...	10	00
67.	„ D. Sundareswaran	...	10	00
68.	„ R. Vijaya	...	10	00
69.	„ Major V. T. Naidu	...	10	00
70.	„ G. Santhana Mary	...	10	00
71.	„ Mrs. S. Joseph	...	5	00
72.	Mr. P. Velusamy, Attender, C. D. M. A.	...	5	00
73.	Dr. J. G. Shanmughanathan	...	5	00
	Contribution from the C. D. M. A. ...	...	607	50

		4,000	00
The Madras Clinical Journal	...	1,000	00
		5,000	00

Dr. T. V. Sivanandam has kindly agreed to pay Rs. 150/- every month till the duration of the national emergency.

List of members and their ladies of the C. D. M. A. who have donated gold ornaments to the National Defence Fund.

1.	Smt. Sundaram Sivanandam	...	One pair of bangles
2.	Dr. Mrs. K. M. Jalajam	...	One ring with a letter 'J'
3.	Kumari Annapurani Sivanandam	...	One pair of bangles
4.	Dr. P. Rukmini	...	One bangle
5.	„ N. S. Palaniappan	...	A ring with letter 'P'
6.	„ R. A. Rahman	...	One pair of bangles
7.	„ P. K. Kalyanaraman	...	One gold ring
8.	„ Mrs. Anna Vareed	...	One sovereign
9.	„ S. G. Rajarathinam	...	Two sovereigns
10.	„ Mrs. Sarojini	...	(1) One gold chain (2) Three small rings
11.	„ V. P. Subbian	...	One pair of ear rings
12.	„ S. Ganapathi	...	One gold ring
13.	Smt. Vanajakshi Jagannathan	...	Two pairs of gold bangles

Dr. K. R. Venkatasubba Iyer has kindly donated his lands at Dindigul measuring 7 acres 86 cents to the National Defence Fund.

Contributions by the following members attached to the Government Headquarters Hospital, Coimbatore to the National Defence Fund have been forwarded to the Collector of Coimbatore.

Honorary Staff

			Rs.	nP.
1.	Dr. P. K. Kalyanaraman	...	...	101 00
2.	„ D. Sundareswaran	...	(cheque)	101 00
3.	„ N. Subramaniam	...	...	101 00
4.	„ S. Ganapathy	...	...	50 00
5.	„ (Smt.) Anna Vareed	...	...	50 00
6.	„ A. G. Leelakrishnan	...	(cheque)	50 00
7.	„ S. Balakrishnan	...	...	10 00
8.	„ P. P. Balakrishnan	...	...	50 00
9.	„ S. G. Rajarathinam	...	...	50 00
10.	„ K. R. Venkatesalu	...	...	50 00
11.	„ V. Venugopal	...	...	101 00
12.	„ R. A. Rahman	...	(cheque)	51 00
13.	„ M. Balakrishnan	...	...	50 00
14.	„ V. Sriramulu	...	...	25 00
15.	„ S. V. Swarnambal	...	...	10 00
16.	„ K. Thiruchitrambalam	...	...	151 00
17.	„ (Smt.) K. M. Jalajam	...	...	50 00
18.	„ (Smt.) Saradambal	...	...	25 00
19.	„ (Smt.) K. Manonmani	...	...	50 00
20.	„ N. S. Ramamurthy	...	...	50 00
21.	„ V. P. Subbian	...	...	50 00

			Rs.	nP.
22.	Dr. R. Rajendran	...	25	00
23.	„ R. Vaidyanathan, Medical Officer, Kaniyur	...	51	00
24.	„ Sulaiman	...	11	00
25.	„ Bhoopathy Vijayakrishnan	...	5	00
26.	„ T. G. Ramamurthy	...	5	00
27.	„ P. S. Rugmini	...	5	00
28.	„ Sathiakeerthy	...	5	00
29.	„ (Mrs.) Rahumathunissa	...	5	00
Total ...			1338	00

Service Staff

1.	Dr. M. V. Kurian, M. S., D. L. O., Lond., Asst. District Medical Officer	...	38	50
2.	„ J. Appa Rao, M. B. B. S., Asst. Surgeon	...	14	50
3.	„ (Smt.) L. Lakshmi Vasudevan, M.B.B.S., Asst. Surgeon	...	14	00
4.	„ M. Sivalingam, M. B. B. S., Pathologist	...	13	00
5.	„ T. B. Venugopal, M. B. B. S., Asst. Surgeon	...	13	00
6.	„ (Kum.) P. Rukmini, M. B. B. S., „	...	13	00
7.	„ Mohammed Hashim Sait, M.B.B.S., D.E., Radiologist	...	13	00
8.	„ M. R. Narayanan, D. M. & S., Asst. Surgeon	...	13	00
9.	„ Mir Ghulam Ghouse, M. B. B. S., Resident Medical Officer	...	10	50
10.	„ S. R. Thulasiraman, M. B. B. S., Asst. Surgeon	...	10	50
11.	„ Kum. R. Vijaya, M. B. B. S., D. G. O., „	...	10	50
12.	„ M. Suryanarayanan, M. B. B. S., „	...	10	00
13.	„ T. S. Subbiah, M. B. B. S., „	...	10	00
14.	„ Saraswathi Shanmugham, M. B. B. S., „	...	10	00
15.	„ (Kum.) K. V. Dhatri G. C. I. M., Junior „	...	7	50
16.	„ (Smt.) N. Kunhikutty, M. B. B. S., „	...	13	00
17.	„ Mohammed Sulaiman, M. B. B. S., „	...	11	00
18.	„ T. M. Parameswaran, M. B. B. S., „ (by cheque)	...	100	00
Total ...			325	00

Nagapattinam Branch :

A meeting of the Nagapattinam branch of the I. M. A. was held on 12—10—1962 to condole the death of Dr. A. Thyagarajan, president of the branch on 13—10—1962. Dr. N. Balakrishnan was unanimously elected as the new president of the branch.

Salem Branch :

1. A clinical meeting of the Salem branch of the I. M. A. was held on Saturday, the 20th October 1962, at 6 P. M., Dr. Jayaramachandran presiding.

Three cases of rupture uterus—(i) Ordinary rupture uterus, (ii) Rupture uterus with rupture of the bladder, (iii) Rupture uterus with perforation of the uterus, (iv) One case of Wilms Tumour and (v) A case of Ectopia Vesicae with epi-spadiasis were demonstrated to the members.

A film show on Kenacort and Siquil by M/s. Sarabhai Chemicals—Squibb was shown at the end.

2. An ordinary meeting of the Salem branch of the I. M. A. was held at Thiruchengodu, Salem district on Saturday, the 17th November 1962 at 6 P. M., Dr. Jayaramachandran presiding.

Major G. A. Naidu, M. B., B. S., F. D. S. Honorary Lecturer in Dermatology, Madura Medical College addressed the members on 'Diagnosis and Modern Treatment of Common Skin Diseases'.

The president read out several circulars connected with the war and asked the members present who were prepared to donate blood at the Salem blood bank when and if called for as a matter of national emergency for use among our troops to give their names. 27 members were present. 9 of them gave their names. The doctors of Thiruchengodu played the host for the evening.

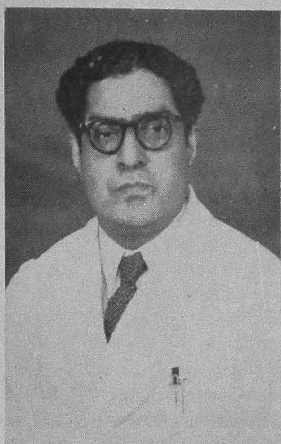
Tiruchy Branch:

A monthly meeting of the association was held on Saturday the 13th October 1962. Dr. T. V. Ranganathan, the president was in the chair.

The president introduced the lecturer of the day Dr. S. Srinivasan, M. B., B. S., D. C. P., L. M., the Srinivasa Clinical Laboratory, Madras to the members and requested him to give his talk on 'Recent Trends in Clinical Pathology'.

OBITUARY

We regret to report the unfortunate demise of Captain A. Thyagarajan, President, Nagapattinam Branch of the I. M. A. on 13th November, 1962.



OBITUARY

Dr. M. G. NAIR

Born 13—11—1905

Died 15—12—1962

We are grieved to learn of the sudden demise of Dr. M. G. Nair, M. B., B. S., T. D. D. (Madras), T. D. D. (Wales), F. C. C. P. (U. S. A.), former Joint Editor of the Madras Clinical Journal and a past President of the Coimbatore District Medical Association at Singapore on the 15th December, 1962.

Born on 13th November, 1905, Dr. Nair had his early education in Palghat and studied for his L. M. P. diploma in Coimbatore and Madras and obtained his diploma in 1929. After qualifying, he served for a short time in Burma and Malaya and in 1932 came back to India and started his practice in Coimbatore. Because of his genial temperament and wide understanding of human nature, he had a very extensive practice. He took a special interest in diseases of the chest and he obtained his T. D. D. in Madras in 1945 and T. D. D. (Wales) in 1948. His aim was to secure a membership of the Royal College of Physicians, England and with this end in view, he studied for and obtained the M. B., B. S., degree of the Madras University in 1953. He was elected to the American College of Chest Physicians in 1958.

For his studies and in between, Dr. Nair travelled extensively in the U. K. and the States and held important senior appointments in some of the big hospitals in both the countries. He was also medical officer-in-charge of the Tuberculosis Department of the Government Headquarters Hospital, Coimbatore for one term. In view of his long service to the public and to the profession, the Coimbatore District Medical Association honoured him by electing him as its President, for 1951—1952 which office he held with distinction. At the time of his death, he was consultant physician at the SATA Hospital, Singapore which post he has been holding for the last 2 years. A keen rotarian, he was a past director of the Coimbatore Rotary Club. He continued his membership of the Rotary International in the Singapore Rotary Club also. An able physician, a sincere friend and a devoted parent, he leaves behind his widow, four sons and three daughters and a host of friends and relations to mourn his loss.

As the Joint Editor of the Madras Clinical Journal for one year, his advice and guidance were of immense help to the editor.

May his soul rest in peace!

STATE PRESIDENT'S APPEAL

You are aware of the crisis our country is facing at present by reason of the Chinese aggression on our territory. The President of India and the Prime Minister of India have exhorted the people of our country to rise up to the occasion and meet the challenge by actively co-operating with the government in their defence efforts.

As members of the medical profession, we have a noble duty to perform in this state of emergency. The Union Health Minister and the State Health Minister have called upon the members of our profession to put their shoulder to the war efforts and help the country in its hour of trial.

Pursuant to the directives of the Health Ministers I venture to make this appeal to all medical men who are members of the Indian Medical Association, and through them to all the other members of the medical profession who are, at present, out of our fold, to offer their services to the Government of India in connection with the defence of our country, and demonstrate that the patriotism of the members of the medical profession is second to none. The government is contemplating the institution of short service commissions in the army; and such of our members who are in a position to take advantage of it are requested to offer their services in the cause of our motherland.

I am sure that this appeal of mine will receive enthusiastic response from our members.

C. NATHAMUNI NAIDU,

20th November, 1962.

President.

* * * * *

I trust you would have received my appeal of 1st November 1962 regarding generous contributions to the National Defence Fund from the members of our association, and that it is engaging your best attention.

It is proposed that the contribution to the National Defence Fund from our members should be presented in the name of THE INDIAN MEDICAL ASSOCIATION at the state level. It is considered that instead of local branches of our association or individual members thereof sending their own contribution to the fund independently, the cause would be served better by consolidating such contributions and presenting the same in a lump sum to the Hon'ble the Chief Minister of the Government of Madras. Such a step will not only be conducive to an organised effort of the medical profession in our state but will also enhance the prestige of the Indian Medical Association in Madras State and help demonstrate its solidarity. Further, it is felt that instead of making small and individual contributions, it would be in keeping with the dignity and status of our members to raise a decent sum and present an attractive cheque in the name of our organisation.

The Madras State Branch of the Indian Medical Association, as on date, consists of roughly 1750 members representing 18 local branches in its jurisdiction. I venture to suggest that if only each member of our association contributes a very nominal sum of - say Rupees (10-00) Ten only, our association will be in a position to present a cheque for a fairly decent amount for the Defence Fund. Affluent members can, of course, contribute more and help to swell the figure. The contributions may be channelised through the local branches or may be made individually. All contributions, either from the local branches or from individual members, may kindly be sent to "THE HON. STATE SECRETARY, INDIAN MEDICAL ASSOCIATION, MADRAS STATE BRANCH, 63, Swami Naicken Street, Chintadripet, Madras-2"; and these will be duly acknowledged. Such receipts will be pooled together and a consolidated cheque will be presented to the Chief Minister of the State in due course.

I hope and trust that my proposal will receive the approval of all the branches and their members, and will be given effect to.

C. NATHAMUNI NAIDU,

20th November, 1962.

President.

The National Defence Fund
(Donations through the Madras State Branch, I. M. A.)

The hon. state secretary, Madras state branch of I. M. A. gratefully acknowledges receipt of the following donations made to the National Defence Fund - received through Dr. M. Narayana Shenoy, B. Sc., M. B. B. S., president of the Erode branch of I. M. A. :—

	Rs.	
1. Dr. L. K. Muthuswamy, M. B. B. S., Erode	100—00	and a
2. „ K. A. Subramaniam, G. C. I. M., (an observer)	100—00	gold medal
		and a
3. „ M. Narayana Shenoy, B.Sc., M.B.B.S., Erode	50—00	gold medal
4. „ M. Mukunda Shenoy, L. M. P., Erode	51—00	
5. „ P. K. Krishnamurthy, M. B. B. S., Erode	50—00	
6. „ N. S. K. Swamy, Erode	50—00	
7. „ S. Badruddin, M. B. B. S., Erode	50—00	
8. „ D. Palaniappan, M. B. B. S. Bhavani	51—00	
9. „ N. Ramachandran, L. M. P., Erode	30—00	
10. „ Smt. A. V. Maragathavalli, M. B. B. S., Erode	25—00	
11. „ E. S. Venkataramanan, L. M. P., Erode	25—00	
12. „ N. B. Sambamurthy, M. B. B. S., L. O., Erode	25—00	
13. „ S. Subrahmaniam, Erode	10—00	
14. „ V. Muthuveerappan, Chittode	10—00	
15. „ Capt. R. S. K. Raman, Erode	25—00	
16. „ P. K. Rajan, L. I. M., (a sympathiser)	25—00	
17. „ K. K. Krishnan, (a sympathiser)	25—00	

	Rs.
18. Dr. R. Venkataratnam, Perundurai	25—00
19. „ V. Ramalingam, Kodumudi	25—00
20. „ Smt. Kochamma, Erode	25—00
21. „ Smt. K. Kunhimalu, M. B. S., Erode	10—00
<hr/>	
Total	787—00
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STATE SECRETARY'S ANNOUNCEMENT**SUBSCRIBERS TO THE B. M. J. PLEASE NOTE**

I. M. A. headquarters at Delhi have intimated that the British Medical Association has increased the rate of yearly subscription for one copy of the British Medical Journal from £. 2—12—6 to £. 3—3—0 with effect from 1st January 1962. The REVISED rate of subscription will be equivalent to Rs. 43/- in Indian currency. Hence subscribers to the British Medical Journal THROUGH THE INDIAN MEDICAL ASSOCIATION are requested to note that they will have to send a sum of Rs. 44/- for enrolling them as subscribers as against the existing rate of Rs. 37/- (inclusive of bank charges). Cheques and other remittances should be in favour of "The Hony. State Secretary, Madras State Branch of I. M. A."

63, Swami Naicken St., }
Chintadripet, Madras-2. }

A. PATTABI,
Hony. State Secretary,
Madras State Branch, I. M. A.

THE 17th MADRAS STATE MEDICAL CONFERENCE

The Seventeenth Madras State Medical Conference will be held at Annamalai Nagar, CHIDAMBARAM, South Arcot district, under the auspices of the South Arcot Branch of the Indian Medical Association, sometime in January 1963. The exact dates of the conference and the programme will be published in due course. All the members of the association and office-bearers of all the local branches of I. M. A. in the state are requested to kindly cooperate with the South Arcot branch of I. M. A. in making the conference a grand success.

NATIONAL DEFENCE FUND—DONATIONS BY ALEMBIC GROUP OF INDUSTRIES

A meeting of the workers and the employees of the Alembic group of industries was held to discuss the efforts to be made to meet the present emergency. The meeting was addressed by chairman Shri R. B. Amin who announced a donation of Rs. 5,00,000/- to the National Defence Fund on behalf of the Alembic group, i. e. Alembic Chemical Works Co. Ltd., (2) Alembic Glass Industries Limited and (3) Jyoti Limited.

He also announced the following facilities to the employees who would either be called up or would volunteer to join the armed forces.

- (1) In case of an employee who joins the armed forces or who is called up, when his present salary exceeds his military pay and allowances, the difference will be made good by the company.
- (2) The employees will continue to have lien on their jobs and would be taken back after their release and the period would be treated as continuous on their rejoining.
- (3) Employees will continue to get the increments from the due dates.
- (4) If an employee chooses to continue to contribute his share to the provident fund, the company shall also continue to contribute. (In the event of the death or permanent disability of a member while serving in the forces and on active duty, the full share of company's contribution to the provident fund will be paid.)
- (5) In case of death on active duty or permanent disability, the company will add, where necessary, to any compensation received from the government a sum by way of ex-gratia gratuity as will make the total equal to fifteen months' basic salary.
- (6) Families of members may be continued to stay in the colony quarters.
- (7) Employees who will be joining Lok Sahayak Sena and Territorial Army will be spared for training on those days and at times as required for training. Salary or wages of such employees for the period of training will not be cut.
- (8) Workers would contribute Re. 1=00 towards Defence Donation and would purchase a Five Rupee Defence Bond every month.

Members of the staff would contribute Re. 1=00 towards Defence Donation and would purchase a Ten Rupee Defence Bond every month.

Officers of the company would contribute minimum 1% of the salary towards Defence Donation and would purchase Defence Bond worth 2% of the salary every month.

The employees of the company have decided to contribute one day's salary to the Fund in the first instance.

ANNOUNCEMENTS

The Government have decided to train all the medical officers in Government service, and medical men who are House Surgeons or General Practitioners or in the employ of Local Authorities, in Anaesthesia irrespective of the fact whether they are working in the Medical, Surgical or Gynaecological sections. Members of the profession who desire to have training in Anaesthesia are requested to send their names with their qualifications, nature of profession and their present address to the Director of Medical Services, Madras-6.

Emergency commissions in the Indian Army Medical Corps are being introduced; and members of the profession who would like to second to the Army are requested to communicate their names, qualifications and date of birth and date of their passing the final examination, their experience as a doctor and their present addresses, to the Director of Medical Services, Madras-6.

All private practitioners throughout the State are requested to intimate to the Public Health Authorities, in a post card, all cases of infectious diseases noticed by them, and thus help the Government in preventing infectious diseases in times of national emergency as well as to eradicate the infectious diseases in their early stages.

The attention of all private practitioners in the State is invited to Rule No. 7 (as amended) and to Sub-Rule No. 1 — vide G. O. No. 4235 Health dated 16—12—1953. As per revised Rule 7, a general practitioner who attends the deceased in his last illness has to give information regarding the cause of the death to the Health Officer and to the Registrar of Births and Deaths in Form K. If the general practitioner fails to furnish the medical certificate as required in the Statute, necessary steps have to be taken for obtaining them. A medical practitioner is liable to be prosecuted under Rule No. 14 for failing to do so. All private practitioners are, therefore, requested to adhere to the provisions of these rules in the interests of the Nation as well as their own.

‘CYANAMID INDIA LTD.’ — ANNOUNCEMENT

Effective Thursday, November 1, 1962, the name of “Lederle Laboratories (India) Limited” has been changed to “CYANAMID INDIA LIMITED”. The address of our Company remains the same, namely, “The International” 16, Queen’s Road, Post Box No. 1994, Bombay 1.

The new name will, effective the said date, be used in all our correspondence and transactions.

It would be appreciated if you would incorporate the new name “CYANAMID INDIA LIMITED” in your records in place of “Lederle Laboratories (India) Limited”. This change in name does not involve any change in our organization or in our basic policies.

NOTES ON NEW PRODUCTS

NICINAL 'CIPLA'

For Hypercholesterolemia — to lower cholesterol levels without the side effects produced by Nicotinic Acid when administered in large doses. Nicinal contains Aluminium Nicotinate Complex with Vitamin B₆. Aluminium Nicotinate is slowly and uniformly hydrolysed into free nicotinic acid with nascent aluminium hydroxide which provides a most effective buffering action to nicotinic acid therapy preventing the side effects. Supplied in bottles of 50 and 100 tablets.

CIPULES 'CIPLA'

Cipules are issued in the form of hermetically sealed, soft gelatine capsules containing in high concentration proteolysed extracts of liver and stomach with Ferrous Fumarate, Yeast, Vitamin B₁₂, Folic Acid and Vitamin C. Cipules contains all the necessary haematinic factors and afford ideal therapy for the treatment and prophylaxis of all types of anaemia due to iron deficiency pregnancy and lactation.

*The Broad-range Oral Hypoglycaemic Agent
newly introduced by Bengal Chemical*

DIABINOL tablet

A Chlorpropamide containing drug prepared in a new method

DIABINOL ensures

- lowest single dose therapy
- effective control of Blood-sugar level
- long lasting effect
- less rigid dietary regime
- excellent tolerance
- quick result where other oral antidiabetic agents have failed
- economy in use

DIABINOL is the latest improvement on Sulphonylureas

Supplies:

Tablets containing 100 mg. Chlorpropamide in bottles of 30
For case reports on **DIABINOL** please refer Vol. 10, No. 1, Bulletin of the School of Tropical Medicine and Indian Medical Journal April, 1962 issue

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